

**STATE OF MICHIGAN**  
**DEPARTMENT OF LABOR & ECONOMIC GROWTH**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

In the matter of

XXXXX

Petitioner

v

Golden Rule Insurance Company  
Respondent

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File No. 89187-001

Issued and entered  
This 20<sup>th</sup> day of May 2008  
by Ken Ross  
Commissioner

**ORDER**

**I**

**PROCEDURAL BACKGROUND**

On April 15, 2008, XXXXX, authorized representative of XXXXX (Petitioner), filed a request for external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner of Financial and Insurance Regulation accepted the request on April 23, 2008. The Commissioner notified Golden Rule of the external review and requested the information used in making its adverse determination.

The case presented a medical question so the Commissioner assigned it to an independent review organization, which provided its analysis to the Commissioner on May 7, 2008.

**II**

**BACKGROUND**

The Petitioner receives health care benefits under an individual policy underwritten by Golden Rule Insurance Company.

The Petitioner, who has Guillain-Barre syndrome (GBS), was admitted to the University of Michigan Medical Center on March 9, 2007. On March 16, 2007, she was transferred to the

medical center's acute rehabilitation floor. She was discharged on May 16, 2007.

Golden Rule says the care the Petitioner received from March 16 through May 16, 2007, was rehabilitation and rehabilitation benefits are capped at \$15,000.00 per calendar year. The Petitioner says the care should be considered inpatient hospital care because she required close medical attention as well as rehabilitation in order to prevent her condition from deteriorating. The Petitioner's authorized representative says the outstanding bill for this care is \$166,837.55.

The Petitioner appealed Golden Rule's decision on this care. Golden Rule reviewed the claim but upheld its decision. The Petitioner exhausted Golden Rule's internal grievance process and received a final adverse determination dated February 26, 2008.

### **III ISSUE**

Did Golden Rule correctly process the claims for the Petitioner's care after March 16, 2007?

### **IV ANALYSIS**

#### **Petitioner's Argument**

The Petitioner argues that Golden Rule mischaracterized her care after March 16, 2007, as primarily rehabilitation instead of an inpatient hospitalization. The Petitioner's condition from that date was described by her authorized representative in an October 22, 2007, letter to Golden Rule:

[The Petitioner] was paralyzed. She could not use her hands to call the nurses but instead required a puffer to trigger the alarm. She had no independent movement of her arms or legs. She was catheterized and had numerous [urinary tract infections] (which were treated with antibiotics). She had Heparin injections twice daily to avoid deep venous thrombosis or pulmonary embolism. She had a suction tube which was constantly suctioning the mucous and saliva out of her throat so that she would not drown on her own secretions given that her throat was paralyzed and she had no swallow reflex. She had daily visits from her neurologist to check on the progression or improvement in the disease process. \* \* \* She had nausea, constipation, fatigue and pain. She had numerous lab tests.... She had prosthetic devices placed on her arms and legs to avoid contracture when she slept. She was moved or rolled at regular intervals to prevent bed sores.

XXXXX, MD, who treated the Petitioner during her stay at the University of Michigan Medical

Center, wrote a letter dated October 11, 2007, in support of the Petitioner:

After her acute hospitalization, [the Petitioner] needed ongoing medical and rehabilitative care on an acute rehabilitation unit. Because of the serious nature of [GBS] and likelihood of relapse, it was critical that she be managed closely by a medical service. While rehabilitation was a focus of her care on the [Physical Medicine and Rehabilitation] Service, she also required close, ongoing medical management. \* \* \* It is my medical opinion that [the Petitioner's] condition required hospitalization for medical reasons, and fortunately was able to get rehabilitation at the same time.

The Petitioner believes Golden Rule is required to cover her stay at the University of Michigan Medical Center under her inpatient hospitalization benefit.

#### Respondent's Argument

It is Golden Rule's position that the Petitioner was medically stabilized as of March 16, 2007, when she was transferred to begin receiving rehabilitation services, and that the care from that date was primarily rehabilitation and therefore limited to \$15,000.00 per calendar year.

Golden Rules cites the provision in the Petitioner's policy regarding rehabilitation and extended care facility expense benefits:

Covered expenses include expenses incurred for rehabilitation services or confinement in an extended care facility, subject to the following limitations:

- (A) Covered expenses available to a covered person while confined primarily to receive rehabilitation are limited to those specified in this provision. [Underlining added]  
\* \* \*
- (C) Covered expenses for rehabilitation and extended care facility expenses are limited to a combined maximum of 30 days in a calendar year for each covered person.
- (D) Covered expenses for provider facility services are limited to charges made by a hospital, rehabilitation facility, or extended care facility for:
  - (1) daily room and board and nursing services;
  - (2) drugs and medicines that:
    - (a) are prescribed by a doctor;
    - (b) must be filled by a licensed pharmacist; and

(c) are approved by the U.S. Food and Drug Administration; and

(3) diagnostic testing.

(E) Covered expenses for non-provider facility services are limited to charges incurred for the professional services of rehabilitation medical practitioners.

**Maximum Benefits:** Subject to the limitations otherwise stated in this Rehabilitation and Extended Care Facility Expense Benefits provision, benefits for covered expenses under this provision are limited to \$15,000 per calendar year for each covered person.

Benefits for rehabilitation cease on the earlier of:

(A) the date the combined maximum of 30 days per calendar year has been met or the date the Maximum Benefits stated above have been met; or

(B) when the care ceases to be rehabilitation.

For the purposes of this provision, "provider facility" means a hospital, rehabilitation facility, or extended care facility.

Golden Rule says it sent the Petitioner's records to an outside reviewer who determined that none of the days from March 16 through May 16, 2007, were for acute care – they were primarily for rehabilitation care. An outside reviewer also determined that the Petitioner was medically stabilized on or prior to the date of her transfer to inpatient rehabilitation. The policy says that "medically stabilized"

means that the person is no longer at risk of further deterioration as a result of prior injury or illness and there are no acute changes in physical findings, laboratory results or radiologic results which necessitate inpatient hospital care.

Golden Rule contends that the Petitioner was medically stable after March 16, 2007, and no longer in need of acute care. It believes the services she received after that date were primarily rehabilitative in nature and therefore subject to the limit on rehabilitation benefits. It believes it correctly processed the Petitioner's claims according to the terms of the policy and its assessment of her condition and the services she received.

### Commissioner's Review

Because this case involved medical issues, the Commissioner referred it to an independent review organization (IRO) for analysis and recommendation. The IRO expert is board-certified in internal medicine, holds an academic appointment, and has been in practice for more than 10 years. The IRO expert concluded that the inpatient services the Petitioner received from March 16 to May 16, 2007, were primarily for rehabilitation.

The IRO report said:

The MAXIMUS physician consultant noted that the [Ppetitioner] was treated with intravenous immunoglobulin during this admission. The MAXIMUS physician consultant also noted that the [Ppetitioner] did not require intubation or mechanical ventilation. The MAXIMUS physician consultant further noted that the [Ppetitioner's] hyponatremia and urinary tract infection were treated prior to her transfer to the physical medicine and rehabilitation unit. The MAXIMUS physician consultant explained that the [Ppetitioner] was medically stable at the time of this transfer. The MAXIMUS physician consultant also explained that a review of the medical records showed no documented emergencies requiring intervention or transfer out of the rehabilitation unit. The MAXIMUS physician consultant indicated that the [Ppetitioner] did not receive acute inpatient services during the period at issue in this appeal. The MAXIMUS physician consultant also indicated that the [Ppetitioner] participated in a multidisciplinary inpatient program including physical therapy, occupational therapy, speech therapy, rehabilitative engineering and therapeutic recreation. The MAXIMUS physician consultant further indicated that the [Ppetitioner's] overall medical condition was followed during this period and that any change in her condition would have resulted in a transfer out of the rehabilitation unit. The MAXIMUS physician consultant explained that the records provided for review do not demonstrate that the [Ppetitioner] received anything other than rehabilitation services during the period at issue in this appeal.

The Commissioner is not required in all instances to accept the IRO expert's recommendation. However, the IRO recommendation is afforded deference by the Commissioner; in a decision to uphold or reverse an adverse determination the Commissioner must cite "the principal reason or reasons why the commissioner did not follow the assigned independent review organization's recommendation." MCL 550.1911(16) (b). The IRO's analysis is based on extensive experience, expertise, and professional judgment. The Commissioner can discern no reason why that judgment should be rejected in the present case. Therefore, the Commissioner accepts the

conclusion of the IRO that the inpatient services the Petitioner received from March 16 to May 16, 2007, were primarily for rehabilitation and did not constitute acute hospital care.

**IV  
ORDER**

The Commissioner upholds Golden Rule's adverse determination of February 26, 2008.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the Circuit Court for the county where the covered person resides or in the Circuit Court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, P. O. Box 30220, Lansing, MI 48909-7720.

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Ken Ross  
Commissioner